UTAH STATE PLAN ATTACHMENT 4.19-D

NURSING HOME REIMBURSEMENT

FOR SERVICES AFTER JUNE 30, 1981

NURSING HOME REIMBURSEMENT

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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100 GENERAL DESCRIPTION

110 INTRODUCTION

Attachment 4.19-D covers two types of providers. One is a licensed nursing facility (NF). The other is an intermediate care facility for the mentally retarded (ICF/MR). The cost definition and reporting are similar.

200 DEFINITIONS

FACILITY:	An institution that furnishes health care to patients.
PROVIDER:	A licensed facility or practitioner who provides services to Medicaid clients.
STATE:	The State of Utah, Department of Health, Division of Health Care Financing.
ACCRUAL BASIS:	That method of accounting wherein revenue is reported in the period when it is earned, regardless of when it is collected and expenses are reported in the period in which they are incurred, regardless of when they are paid.
PLAN:	The Medicaid plan prepared by the State of Utah in response to Federal program requirements for Title XIX, ATTACHMENT 4.19-D.
HCFA - PUB. 15-1:	The Medicare Provider Reimbursement Manual published by the U.S. Department of Health and Human Services that defines allowable cost and provides guidance in reporting costs.
PATIENT DAY:	Care of one patient during a day of service. In maintaining statistics, the day of admission is counted as a day of care, but the day of discharge is not counted as a day of patient care.
FCP:	The Facility Cost Profile (FCP) is the cost report filed by providers.
DEPARTMENT:	Utah State Department of Health.
NURSING FACILITY:	A licensed nursing facility (NF) that provides long term care.
ICF/MR:	A licensed Intermediate Care Facility for the Mentally Retarded that provides long term care.

300 REPORTING AND RECORDS

310 INTRODUCTION

This section of the State addresses five major areas: (1) the accrual basis of accounting; (2) reporting and record keeping requirements; (3) FCP reporting periods; (4) State audits; and (5) federal reporting.

320 BASIS FOR ACCOUNTING

Long-term care providers must submit financial cost reports which are prepared using the accrual basis of accounting in accordance with Generally Accepted Accounting Principles. To properly facilitate auditing and rate calculations, the accounting system must be maintained so that expenditures can be grouped in accounting classifications specified in the facility cost profile (FCP).

330 REPORTING AND RECORD KEEPING

The FCP is the basic document used for reporting historical costs, revenue and patient census data. The FCP is sent to providers at least 60 days prior to the due date.

331 FACILITY COST PROFILES

The FCP represents the basis for establishing the data base that is used to calculate rate. Therefore, it is essential that the FCPs are filed with accurate and complete data. Non-allowable costs should not be included on the FCP. The provider, and not the auditor authorized by the State, is responsible for the accuracy and appropriateness of the reported information.

332 REPORTING

The FCP is due two months after the end of the reporting period. The provider may request a 15-day extension for extenuating circumstances. The request must be made in writing prior to the due date. The State may grant a 15-day extension only when justified. Failure to file timely FCPs can result in the withholding of payments as described in Section 720.

333 RECORD RETENTION

The State is responsible for keeping the FCPs on file for at least four years following the date of submission. The provider is responsible for maintaining sufficient financial, patient census, statistical, and other records for at least four years following the date of the FCP submission. These records are to be made available to representatives of the State and Federal Governments. The records must be in sufficient detail to substantiate the data reported on the FCP.

340 REPORTING PERIODS

Generally, the FCP reporting period is for twelve months. However, when there is a new facility or a change in owners or operators, there may be reporting periods of less than twelve months. The reporting period is January 1 through December 31 for NFs and July 1 through June 30 for ICF/MRs. Other reporting periods must be approved by the Department of Health. For exceptions to the designated reporting period, the provider must submit a written request 60 days prior to the first day of the reporting period and the State must issue a written ruling on the request.

350 STATE AUDITS

The State will desk review all FCPs and perform selective audits. In completing the audits, the State, either directly or through contract, will provide for an on-site audit of selected FCPs. The auditor is responsible for verifying the reported reasonable costs. The appropriateness of these costs is to be judged in accordance with the intent of the guidelines established in HCFA-Pub. 15-1, except as otherwise stated in this plan. Audits are conducted in accordance with generally accepted auditing standards. Audits are primarily oriented toward verification of costs reported on the FCP. In determining if the costs are allowable, the auditor examines documentation for expenditures, revenues, patient census and other relevant data.

400 ROUTINE SERVICES

410 INTRODUCTION

This section specifies the services covered in the per diem payment rate and the ancillary services that are billed separately. Because of the difficulty of defining all of the routine services, section 430 specifies those services that are billed directly. Other services are covered by the routine payment rates paid to long-term care providers.

420 ROUTINE SERVICES

The Medicaid per diem payment rate covers routine services. Such routine services cover the hygienic needs of the patients. Supplies such as toothpaste, shampoo, facial tissue, disposable briefs, and other routine services and supplies specified in 42 CFR 483.10 are covered by the Medicaid payment rate and cannot be billed to the patient. The following types of items will be considered to be routine for purposes of Medicaid costs reporting, even though they may be considered ancillary by the facility:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas.

2. Items furnished routinely and relatively uniformly to all patients, such as patient gown, water pitchers, basins, and bedpans.

3. Items stocked at nursing stations or on the floor in gross supply, such as alcohol, applicators, cotton balls, bandaids, suppositories, and tongue depressors.

4. Items used by individual patients which are reusable and expected to be available such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment.

5. Special dietary supplements used for tube feeding or oral feeding except as provided in Section 430 item 3.

6. Laundry services.

7. Annual dental examination for ICF/MR patients only.

8. Transportation to meet the medical needs of the patient, except for emergency ambulance.

9. Medical supplies and non-prescription pharmacy items. Supplies include, but are not limited to: syringes, ostomy supplies, irrigation equipment, dressings, catheters, elastic stockings, test tape, IV set-up, colostomy bags, etc.

10. Medical consultants.

11. Physical therapy, occupational therapy, speech therapy and audiology examinations for ICF/MR patients only.

12. All other services and supplies that are normally provided by long-term care providers except for the non-routine services specified in Section 430.

430 NON-ROUTINE SERVICES

These services are considered ancillary for Medicaid payment. The costs of these services should not be included on the FCP, but should be billed directly. Such billings are to be made by the supplier and not the long-term care provider. These services are:

1. Physical therapy, speech therapy, and audiology examinations for nursing facility patients only.

2. Oxygen.

3. Prescription drugs (legend drugs) plus antacids, insulin and total nutrition, parenteral or enteral diet given through gastrostomy, jejunostomy, IV or stomach tube. In addition, antilipemic agents and hepatic agents or high nitrogen agents are billed by pharmacies directly to Medicaid.

4. Prosthetic devices to include (a) artificial legs, arms, and eyes and (b) special braces for the leg, arm, back and neck.

5. Physician services for direct patient care.

6. Laboratory and radiology.

7. Dental services except annual examinations for ICF/MR patients.

8. Emergency ambulance for life threatening or emergency situations.

9. Other professional services for direct patient care, including psychologists, podiatrists, optometrists, and audiologists.

10. Eye glasses, dentures, and hearing aids.

11. Special equipment approved by Medicaid for individual clients is covered. This equipment is currently limited to air flotation beds and water flotation beds that are self-contained, thermal regulated, and alarm regulated, and mattresses and overlays specific for decubitus care, and customized (Medicaid definition) and motorized wheelchairs.

431 DEFINITION OF PROSTHETIC DEVICES

Medicaid defines prosthetic devices to include (1) artificial legs, arms, and eyes; (2) special braces for the leg, arm, back, and neck; and (3) internal body organs. Specifically excluded are urinary collection and other retention systems. This definition requires catheters and other devices related to be covered by the per diem payment rate.

500 ALLOWABLE COSTS

501 GENERAL

Allowable costs will be determined using the Medicare Provider Reimbursement Manual (HCFA-Pub. 15-1), except as otherwise provided in this Plan.

520 OWNERS COMPENSATION

Owners and their families may claim salary costs as permitted by HCFA-Pub. 15-1.

530 FRINGE BENEFITS

Benefits are allowed as permitted by HCFA-Pub. 15-1.

540 ALTERNATIVE PROGRAMS

Some long-term care providers provide specialized programs which are not covered by Medicaid. One such program is day care for older people living in their own homes. Such programs are carved out of the FCP as non-allowable costs. In completing the cost finding for the Medicaid program, two alternatives are available. First, at the election of the provider or when prior approval is not obtained, Medicare cost-finding methodology will apply. Under Medicare cost-finding the specialized program receives its share of overhead allocation on a step-down schedule incorporated in the annual cost report. However, the provider may submit and the State may approve, alternative revenue offsets as opposed to cost finding. Advance approval must be obtained prior to the beginning of the reporting period.

600 PROPERTY

600 INTRODUCTION

The purpose of this regulation is to limit increases in property costs to the inflation factor allowed in payment rates.

630 PROPERTY FACTORS

Due to the wide variations in property costs and the financial commitments of providers, a portion of the March 27, 1981, property costs are recognized in addition to the base rate. The variation in property costs is recognized in two ways: (1) based on the property costs on March 27, 1981, as incorporated into the July 1, 1981, rates, abd (2) new construction as defined in Sections 631, 632 and 633. Except for new construction, the rate differentials for FY 1994 and subsequent years are the same as the rate differential established on July 1, 1991, when rates were rebased and additional property was added to the base rate. There have been no increases for buying, selling, refinancing, new leases or lease escalation clauses since March 27, 1981. Rather, increases in property costs are recognized by inflating the base rate each year. The inflation index is described in Section 900 and is the basis for negotiating the annual inflation adjustments to nursing facility rates. Therefore, the State does not adopt the Medicare approach of recapturing depreciation.

631 EXCEPTION FOR PROPERTY DIFFERENTIAL

When a nursing facility operated by a State or local government is sold, a property differential will be available for meeting life safety requirements that were previously waived by the State. The differential is based on the annual depreciation calculated for the remodeling. Such depreciation will be determined in accordance with the Provider Reimbursement Manual HCFA-Pub. 15-1. In calculating a per diem cost, a 90% occupancy factor will be used. The property differential will be added to the rate in the month following submission of invoices and other requested records to support the expenditure for such property improvements.

632 NEW CONSTRUCTION DEFINED

New construction is limited to either a new building or a new wing to an existing building. It does not include modifying or refurbishing an existing structure.

633 NEW CONSTRUCTION PROPERTY DIFFERENTIAL

The property differential for new construction and related property costs will be the lesser of:

1. Actual property costs in excess of the property cost included in the base rate. The property cost in the base rate is calculated at $8.95 per day for the period beginning July 1, 1995. This figure was inflated forward to $11.19 for Fiscal Year 2003.

2. The simple average property differential of all nursing facilities that have a property differential. This is the new property allowance.

700 PAYMENT TO PROVIDERS

710 INTRODUCTION

Payments for routine nursing facility services will be made monthly. These payments will be based on the established rate.

720 WITHHOLDING PAYMENTS

In order to assure compliance with selected policy and to assure collection of outstanding obligations, the State may withhold payment for the following reasons:

1. Shortages in Patient Trust Accounts

   Upon written notification that an examination of a patient trust fund account revealed an irreconcilable shortage, the facility must make a cash deposit in the full amount of the shortage within 10 days of notification. Within 30 days of such notification, documentary evidence must be presented to the Division of Health Care Financing attesting to this deposit. Failure to comply with this requirement will result in the withholding of the Title XIX payments. The cash transaction to transfer cash to the patient's account is not an allowable cost.

2. Failure to Submit Timely FCPs

   Reporting period requirements are specified in Section 332 title "Reporting". If the provider fails to meet these requirements, the State may withhold payment until such time as an acceptable FCP is filed. FCPs must be complete before they are considered filed.

3. Liabilities to the State

   When the State has established an overpayment, payments to the provider may be withheld. However, if the provider is an ongoing operation and if the provider can demonstrate serious cash flow problems, the State may accept a repayment schedule signed by the provider. Normally, this repayment schedule should not exceed 90 days. For ongoing operations, the State will provide 30-day notification before holding payments. This 30-day period is to give the provider time to appeal the appropriateness of the overpayment determination. The State may waive the 30-day notification period if there is cause to believe the delay will unduly jeopardize the collection.

730 LIMITATIONS ON PAYMENT

No payment rate or other settlements will exceed the facility's charges to the general public for the reporting year. In applying this limitation, the State will use the regulations established by the Medicare program, including HCFA-Pub. 15-1. The purpose of this limitation is to assure that the Medicaid program does not pay more than the general public for health care services. Providers should not use the Medicaid rate as a basis for justifying rate increases to the general public. Rather, they should use the private market forces to limit Medicaid payment. Payments will not exceed the upper limit for specific services as defined by 42 CFR 447.253. The comparison of the Medicaid and the private rates will be made in the aggregate for all patients for a twelve-month period with one exception. To give providers an opportunity to give advanced notice to private patients, the period July 1, 1995 through July 31, 1995, is excluded from the comparison.

800 APPEALS

810 INTRODUCTION

The State recognizes the need for a provider appeals procedure to provide some assurance of fair and equitable treatment. It is intended that this procedure will resolve many of the reimbursement disagreements before formal lawsuits are initiated. The appeal process involves a quasi-judicial forum for hearing grievances.

820 FILING PROCEDURES

The following procedures apply:

1. The appeal must identify a specific audit adjustment or rate calculation.

2. The appeal must include reference to specific policies and regulations.

3. The appeal must be made within 30 days from the date of notification of final audit settlement or a revised payment rate.

4. The appeal must include copies of pertinent documents such as payroll records, invoices, etc.

830 PURPOSE OF APPEALS

The appeal procedure is intended to allow individual providers an opportunity to submit additional evidence and receive prompt administrative review of payment rates with respect to such issues as the agency determines appropriate rates.

900 RATE SETTING FOR NFs

900 GENERAL INFORMATION

Rate setting is completed by the Division of Health Care Financing (DHCF). Cost and utilization data is evaluated from facility cost profiles. The annual Medicaid budget requests include inflation factors for nursing facilities based on the Producer Price Index published by the U.S. Department of Labor, Bureau of Labor Statistics. The actual inflation will be established by the Utah State Legislature based on economic trends and conditions. Consideration will be given to the inflation adjustments given in prior years relative to the Producer Price Index.

920 RATE SETTING

Effective January 1, 2003, the base line per diem rate for all patients in the facility consists of: 1) a RUGs component, 2) a fixed rate component, and (3) a property differential component. The components are based on historical costs reported on facility cost profiles (cost reports). The historical cost calculation, although utilizing the facility cost profiles, will be adjusted to account for Medicare payments (netted from total costs), and certain "add on" payments including, intensive skilled payment enhancements, specialized rehabilitation services (SRS) payment enhancements, behaviorally challenging payment enhancements and finally any other enhancement payments that Medicaid may initiate in the future. Historical costs, except for property related costs, are arrayed for each cost center and the 50% percentile is used as the Areasonable costs@ base line. Base line per diem rates are the per diem payment rates net of special "add-ons" for individual patients, as discussed above.

920b BEHAVIORALLY CHALLENGING PATIENT ADD-ON

This "add on" which was effective July 1, 2003, was designed to recognize and compensate providers for patients that require an inordinate amount of resources due to the intensive labor involved in their care.

Behaviorally challenging patients are defined as follows:

Behaviorally complex resident means a Long Term Care resident with a severe medically based behavior disorder (including but not limited to Traumatic Brain Injury, Dementia, Alzheimer, Huntington's Chorea) which causes diminished capacity for judgment, retention of information and/or decision making skills, or a resident, who meets the Medicaid criteria for Nursing facility level of care, and who has a medically based mental health disorder or diagnosis and has a high level resource use in the Nursing facility not currently recognized in the case mix system.

To qualify for a behaviorally challenging patient "add on" the provider must document that the patient involved meets the following criteria:

- The resident meets the criteria for Nursing facility level of care as found in the Utah Administrative Rule: Nursing Facility Levels of Care, R414-502,
- The resident has a primary diagnosis which is identified with the appropriate ICD9 code on the MDS as listed:
  - ICD9-331, Alzheimer's Disease,
  - ICD9-290, Dementia Other than Alzheimer's. This can include organic brain syndrome (OBS), chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurological disease other than Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.),
  - ICD9-854, Traumatic Brain Injury (TBI).
- And, the resident has a history of regular/recurrent persistent disruptive behavior which is not easily altered evidenced by one or more of the following which requires an increased resource use from Nursing facility staff:
  - The resident engages in wandering behavior moving with no rational purpose, seemingly oblivious to their needs or safety,
  - The resident engages in verbally abusive behavioral symptoms where others are threatened, screamed at, cursed at,
  - The resident engages in physically abusive behavioral symptoms where other residents are hit, shoved, scratched, and sexually abused,
  - The resident engages in socially inappropriate/disruptive behavioral symptoms by making disruptive sounds, noises, screaming, self-abusive acts, sexual behavior or disrobing in public, smearing/throwing food/feces, hoarding, rummaging through others belongings,
  - The resident engages in behavior that resists care by resisting medications/ injections, Activities of Daily Living (ADL) assistance, or eating.
- And, the Nursing Facility staff shall have established behavior baseline profile of the resident following R414-502-4 (6)(a) through (g) guidelines and implemented a behavior intervention program designed to reduce/control the aberrant behaviors, and a specialized document program that increases staff intervention in an effort to enhance the resident's quality of life, functional and cognitive status.

It should be noted that any MR/DD residents who are receiving the specialized rehabilitation services (SRS) add on rate will be excluded from receiving this add on rate.

Facilities that document patients that have behaviorally challenging problems as defined above will be paid an "add-on" rate as described in §930.

921 RUGs B NURSING COMPONENT

The Resource Utilization Groups (RUGs) is a severity-based payment system. A facility case mix system is employed in the computation of the RUGs component of the per diem payment rate. Case mix is determined by establishing a RUGs weight for each patient. Available RUGs scores for each patient are combined with the scores of all other patients to establish a composite weight for all patients in the facility. The composite weight is multiplied by a dollar conversion factor to arrive at a per diem amount for the facility payment rate. The "dollar conversion factor" is defined as the rate established yearly by the state that is determined as a result of consideration of the average case mix changes and the necessary resources to maintain proper care levels for the patients. For all practical purposes this is a rate which having been established in the initial year commencing January 1, 2003, will be updated to recognize proper increases necessitated by normal cost increases. The initial case mix or "dollar conversion factor" established on January 1, 2003 was set at $52.55 ppd. The entire rate on average for all facilities utilized on this date was therefore composed of the three components; property component, the case mix component and flat rate component which is outlined as follows:

Components as of January 1, 2003
(initial period of the new case mix payment system)

Property Component:	$11.19
Case Mix Component:	$52.79
Flat Rate Component:	$41.57
Total Average Rate:	$105.55

Example: a rate determination of facility A-1 Care (hypothetical) which had a case mix or severity index of .8154 and a qualified property amount of $11.19 ppd (minimum granted) is as follows:

Property Payment ppd.:	$11.19
Case Mix Component:	
Index x Case Mix Component ppd:	
Or .8154 x $52.79	$43.05
Flat Rate Component ppd:	$41.57
Total Rate	$95.81

Please note that urban / rural adjustment was not considered in this example as this was presented to demonstrate the use of a case mix adjustment on the rate only.

For the period January 1, 2003 through June 30, 2004, the facility case mix will be calculated quarterly resulting in quarterly rate setting.

922 FLAT RATE B NON-NURSING COMPONENT

The flat rate is a fixed amount paid for all Medicaid patients. The flat rate category is increased periodically for inflation. The flat rate component includes: (1) general and administrative, (2) property and related expenses (net of the property differential), (3) plant operation and maintenance, (4) dietary (including dietary supplements), (5) laundry and linen, (6) housekeeping, (7) ancillary nursing costs separate from nursing salaries, wages and benefits paid under RUGs, and (8) recreational activities. The flat rate established in the first year of the severity based payment project commencing January 1, 2003 reflects the proportion of the overall nursing home rate that is considered to not be variable in nature. The base year or initial year flat rate commencing January 1, 2003 was determined to be $41.57 ppd.

923 PROPERTY (BASE AND DIFFERENTIAL)

All patient per diem rates includes $11.19 in the flat rate component based on historical property payments. Some providers receive a property differential in their per diem rate. The property differential is the amount between $11.19 and the $20.00 ceiling. While many of the nursing facilities will not qualify because their property costs are below $11.20, others will receive between $.01 and $8.81 per day based on allowed property costs reported on the FCP above $11.19 per day. The $11.19 per day was based on $8.66 in the FY 1995 rates inflated to $11.19 for FY 2003 rates.

In determining the amount of the property differential, the calculated cost per day is reduced when occupancy is below 75%. Property cost allowed on the 2001 FCP is divided by the greater of 1) reported patient days or 2) licensed beds times 365 days times 75%.

924 NEW FACILITIES

Newly constructed facilities are paid the average per diem base rate. This average rate will be paid for up to six months at which time, the provider's case mix index will be established. A new prospective rate will be paid. Thereafter the property payment to the facility will be controlled by R414-504-3(5).

An existing facility acquired by a new owner will continue with the same per diem payment rate (same case mix index and property component established for the previous ownership.)

925 PROPERTY PHASE-OUT

Property payments will be phased out by reducing the payment by 25% of the January 1, 2003 amount for each of the succeeding three calendar years, with all property payments being phased out effective January 1, 2006.

926 UNDERSERVED AREAS

When the Medicaid agency determines that a facility is located in an underserved area, or addresses an underserved need, the Medicaid agency may negotiate a payment rate that is different from the case mix index established rate. This exception will be awarded only after consideration of historical payment levels and need. An "underserved area" is defined and determined by the following criteria (which includes operational information concerning state procedures):

(a) A sole community provider that is financially distressed may apply for a payment adjustment above the case mix index established rate.

(b) The application shall propose what the adjustment should be and include a financial review prepared by the facility documenting:
   (i) the facility's income and expenses for the past 12 months; and
   (ii) steps taken by the facility to reduce costs and increase occupancy.

(c) Financial support from the local municipality and county governing bodies for the continued operation of the facility in the community is a necessary prerequisite to an acceptable application. The Department, the facility, and the local governing bodies may negotiate the amount of the financial commitment from the governing bodies, but in no case may the local commitment be less than 10% of the state share required to fund the proposed adjustment. The applicant shall submit letters of commitment from the applicable municipality or county, or both, committing to make an intergovernmental transfer for the amount of the local commitment.

(d) The Department may conduct its own independent financial review of the facility prior to making a decision whether to approve a different payment rate.

(e) If the Department determines that the facility is in imminent peril of closing, it may make an interim rate adjustment for up to 90 days.

(f) The Department's determination shall be based on maintaining access to services on and maintaining economy and efficiency in the Medicaid program.

(g) If the facility desires an adjustment for more than 90 days, it must demonstrate that:
   (i) the facility has taken all reasonable steps to reduce costs, increase revenue and increase occupancy;
   (ii) despite those reasonable steps the facility is currently losing money and forecast to continue losing money; and
   (iii) the amount of the approved adjustment will allow the facility to meet expenses and continue to support the needs of the community it serves, without unduly enriching any party.

(h) If the Department approves an interim or other adjustment, it shall notify the facility when the adjustment is scheduled to take effect and how much contribution is required from the local governing bodies. Payment of the adjustment is contingent on the facility obtaining a fully executed binding agreement with local governing bodies to pay the contribution to the Department.

(i) The Department may withhold or deny payment of the interim or other adjustment if the facility fails to obtain the required agreement prior to the scheduled effective date of the adjustment.
(j) The additional payment provided to a facility as a result of this provision may not exceed the reasonable and documented cost of providing the services involved. Additionally, the additional payment may not be less than the cost of providing at a minimum the "variable" or incremental cost involved in providing the service.

927 RATE DISAGREEMENTS

Providers may challenge the established payment rate pursuant to this SPA amendment using the appeals process set up by R410-14. Providers must exhaust administrative remedies before challenging rates in State or Federal Court.

928 WAGE INFLATION DIFFERENTIAL

Nursing salary costs (RUGs rate component) will be adjusted by the urban/rural inflation differential. The wage index adjustment compares the average cost of nursing per day in urban and rural areas. Urban and rural areas are defined in Attachment 4.19-A Section 110 of the State Plan. Urban areas include Washington, Utah, Salt Lake, Davis, Weber and Cache counties. These are officially recognized Standard Metropolitan Statistical Areas (SMSAs) as designated by Centers for Medicare and Medicaid Services (CMS). The remaining countries are designated as rural.

929 LIMITATION ON RATE REDUCTIONS UNDER NEW RUGS

The calculated payment rate will include a hold harmless determination so that no facility will be paid less than $5.00 per day than their rate on July 1, 2002. This hold harmless provision ends on June 30, 2004.

930 BEHAVIORALLY CHALLENGING PATIENT ADD-ON

Behaviorally challenging patients may qualify for a special add-on payment rate. The rate established for the base year of 2002 is considered to be $6.60 per patient day (ppd). This rate was determined after extensive "on site" time studies at providers sites. The study determined that additional time involved by all levels of nursing care for these patients, and applied an average amount per hour. This study will be updated on an "as needed" basis.

931 SPECIALIZED REHABILITATION SERVICES (SRS) FOR INDIVIDUALS

An amount is added to the facility rate that pertains to approved patients. Because the SRS rate is paid in addition of the facility specific rate, the resulting revenue is offset against the nursing costs on the FCP.

1000 SPECIAL RATES INTENSIVE SKILLED

1010 INTRODUCTION

The objective of this section of the State Plan is to provide incentives for nursing facilities to admit high cost patients from hospitals. Typically these patients are ventilator dependent or have a tracheotomy. Even though the rate paid to the nursing facility is much higher than the NF rate, it is much lower than the hospital rate.

1020 RATE DETERMINATION

Each qualifying patient will have a contract rate which is determined by negotiations between the State and the nursing facility. The rate will consider specialized equipment and supplies as well as specialized care, including special rehabilitative needs. The rate will be in effect for a period specified in the contract.

1030 QUALIFYING PATIENTS

To qualify for a special contract rate, the patient must meet the criteria of the intensive skilled level of care. Prior approval is required.

1100 ICF/MR FACILITIES

1101 INTRODUCTION

This section deals with two types of ICF/MR providers -- community providers and the State Development Center.

1110 BACKGROUND

As a result of the active treatment requirements imposed by federal regulations, special consideration is given to payment rates for institutions for the mentally retarded. A specific all-inclusive flat rate is negotiated each year for the patients in each facility with the exception of the State Developmental Center (formerly the Utah State Training School). A single per diem rate is paid for all patients in the facility. The rate covers all service normally provided by ICF/MR facilities. These services are discussed in more detail in Section 400. In addition to Section 400, the following additional clarification is provided:

1. Psychological testing and evaluation, as well as brain stem tests, are covered in the flat rate.

2. Day treatment services are incorporated into the flat rate. These services may vary depending on the needs of the patients.

3. Transportation to day treatment centers is included in the ICF/MR flat rate.

1112 INCORPORATION OF OTHER RULES

The reimbursement methodology for ICF/MR community providers incorporates sections 100 through 800 of Attachment 4.19-D to the State Plan.

In addition, the Facilities Cost Profile cost report is adopted with the following clarifications and/or modifications: (1) The per diem cost is based on the composite ICF/MR-1, ICF/MR-2 and ICF/MR-3 days and costs; (2) Cost center 01 account 05 (Employee taxes or benefits) is either direct cost or allocated based on direct salary and wage expenditures; (3) Return on equity is calculated and reported using Medicare regulations; and (4) Cost centers 07 and 08 are expanded to identify active treatment costs including physical therapy, occupational therapy, audiology, psychologists, teachers, inservice and habilitation aids.

1131 CLARIFICATION REQUESTS

Some provisions of the new reimbursement system may require clarification. Written requests may be submitted for more detailed explanation. Further, the State may clarify provision of the State Plan through provider bulletins and provider manual revisions.

1114 ALLOWABLE COSTS

HCFA-Publication 15-1 Medicare interpretations will be used to define “allowable costs” unless otherwise specified by the State Medicaid Plan.

1115 NEW OWNERS

In the event an ICF/MR facility is sold or leased to a new operator, the new operator will be jointly liable for any retroactive cost settlements. The State reserves the right to withhold retroactive cost settlements from current payments.

1190 ICF/MR PUBLIC INSTITUTION

The ICF/MR public institution (Utah State Developmental Center) is to be reimbursed retrospectively. This institution stands alone as a special provider of services. The size and characteristics of this facility require an independent categorization. The needs for this categorization include:

1. Its actual costs are not stated on a basis suitable for comparison with other ICF/MRs.

2. It is approximately seven times larger than any other ICF/MR and, therefore, comparison between it and facilities which rage in size from 43 to 103 beds is questionable.

3. The majority of the patients are profoundly impaired. They require more specialized and intensive services than ICF/MR patients in community facilities.

The treatment of the ICF/MR public institution in a separate category was recommended by Lewin and Associates, a private consulting firm.

In general, retrospective reimbursement uses an average per diem cost approach. Allowable costs are divided by patient days to determine the cost per patient day. Costs are reported on the facility cost profile (FCP). HCFA Provider Reimbursement Manual (HCFA-Pub. 15-1) is used to define allowable costs for FCP reporting purposes unless otherwise specified. One exception to the Provider Reimbursement Manual is the asset capitalization policy. This exception permits the ICF/MR public institution to only capitalize those assets costing more than $5,000.

1200 FY 1994 AVERAGE RATE COMPONENTS

Not Used

1300 QUALITY OF CARE INCENTIVE

Deleted 7-1-93

1400 HOSPICE CARE

1410 INTRODUCTION

Hospice services are provided through home health agencies. The rates are described in Attachment 4.19-B Section DD.

1500 FEE INCREASE

Effective July 1, 1989, the base payment rates for NF-1, NF-2, and NF-3 were increased for provisions of the 1987 and 1990 Omnibus Budget and Reconciliation Acts (OBRA). The increase in the daily rates reflects the projected cost of wage adjustments for nurse aides plus an additional amount for OBRA requirements that are considered to be covered by the historical rate setting system. The historical service considered to be part of the base rate include medical supervision, dietary consultation, social services, recreational therapy, psycho social, pharmacy consultation, dental consultation, resident assessment, plan of care, resident personal funds, resident rights and medical records. The rate increases are as follows:

1. Increase wages for trained nurse aides $2.54 per day

2. Increase for general OBRA requirement .52 per day

   Total (NF-1, NF-2, and NF-3) $3.06 per day

On July 1, 1990, the current base payment rates, including the OBRA amounts in the base rates, are increased by 6.4% inflation. Specific increases for OBRA are as follows:

1. Patient rates for NF-2 and NF-3 levels of care are increased by $.03 for emergency power requirements.

2. Patient rates for NF-2 and NF-3 levels of care are increased by $.95 for increased licensed nurse requirements.

1600 REBASING PAYMENT RATES

1610 REBASING RATES

Effective for the period July 1, 1991 through June 30, 1992, the payment rates for nursing facilities are increased based on costs reported on the Facility Cost Profile (FCP). These cost data are inflated for current economic trends and conditions. The inflation is calculated through June 30, 1992, using the methodology referenced in Appendix III to Attachment 4.19-D. Historical weights identified in Appendix C to the KMG Main Hurdman study are used to arrive at a composite inflation factor. Current inflation indices are used based on the midpoint of the cost reporting year and the midpoint of FY 1992. The following methodology is used to establish the new rates:

1. The most recent facility cost profiles are obtained for each free-standing nursing facility.

2. Costs are audited and adjusted by an independent CPA firm.

3. The average costs per day are calculated for each cost center for each nursing facility.

4. The costs are adjusted for low occupancy, using factors of 60% fixed costs and 40% variable costs.

5. The costs per day are inflated through June 30, 1992.

6. The costs per day are arrayed for each cost center.

7. The median costs (50th percentile) for “general and administration,” “plant and maintenance,” “laundry,” “housekeeping,” and “recreation” are used to set the statewide flat rate. The per diem costs for “dietary” are included in the rate at the 60th percentile. The per diem cost for “nursing” is included in the rate at the 70th percentile. (These percentiles apply to the periods FY 1991 and FY 1992 only. See Section 1620 for FY 1993 percentiles.)

8. Property is inflated from the FY 1981 rates. Six dollars per patient day is included in the FY 1992 base rates. A property differential in the FY 1991 facility rate above the $6.00 may be added to the base rate. The differential is added only when the inflated property in the FY 1981 base rate plus the FY 1981 property differential exceeds $6.00 and is also supported by current costs. Current costs are those costs included in the FCPs used to compile the data base for rebasing the flat rate.

1620 REBASING RATES

For the period July 1, 1992 through June 30, 1993, payment rates for nursing homes are increased by $5.51 per patient day based on Section 1800. As a result, there is a need to update the percentiles used to support the nursing home rate. The percentiles included in Section 1610 are adjusted upward to reflect increased emphasis on nursing and related costs. The following adjustments to section 1610 apply:

COST CENTER	FY 1992 PERCENTILE	FY 1993 PERCENTILE	PER DIEM INCREASE
General & Administration	50th	55th	$.26
Plant & Maintenance	50th	55th	.18
Laundry	50th	55th	.06
Housekeeping	50th	55th	.08
Recreation	50th	55th	.03
Dietary	60th	70th	.19
Nursing	70th	80th	4.67
Other			.04
Total			$5.51

1700 ICF/MR RATE ADJUSTMENT

1710 INTRODUCTION

The purpose of this section is to define the rate increase for ICF/MR patients. For the period beginning July 2, 1996, rates are increased by a uniform percentage of 3.0% over FY 1996. The increase is added to the FY 1996 rate for each individual facility. This percentage is based on 2.3 % for inflation and 0.7% for additional adjustments for professional staff involved in the day-to-day care of patients. The 2.3% percentage is based on the inflation adjustment calculated using the methodology described in the KMG Main Hurdman Study of the Utah Nursing Home Inflation Index. The state institution for the mentally retarded is not affected by this change because it is reimbursed actual costs under Section 1190 of the plan.

1720 QUALIFICATION

All community ICF/MR facilities qualify for the 3.0% rate increase.

1800 ENHANCED PAYMENT RATES FOR NURSING FACILITY PATIENTS

1800 PAYMENT RATES

Effective July 1, 1992, the payment rates for nursing facilities are increased by $5.51 per day for enhanced services (see Section 1600). A second increase is provided for NF-3 level patients. This increase is calculated by multiplying the FY 1992 base rate by 1.041. The base rate is defined as the flat rate paid to all participating nursing facilities for an NF-3 level patient.

1900 SPECIALIZED REHABILITATION -- MENTALLY RETARDED (NF CLIENTS)

1910 PAYMENTS

A payment rate differential is paid to nursing facilities with mentally retarded clients who need specialized rehabilitative services that are either not covered by the daily payment rate or not available from other providers covered by the State Medicaid Plan. The specialized rehabilitation services must be approved by the Medicaid Patient Assessment Unit. Approval must be obtained before the additional services qualify for the rate differential. The specialized rehabilitation rate differentials are established through negotiations between Division of Health Care Financing and individual nursing facilities. The negotiated rate is based on the estimated direct costs of providing the service. The rate is patient specific for the additional services provided by the Nursing facility. The rate is an average per diem rate for a one month period to coincide with the monthly "payroll" for each nursing home. For example, if the expected cost is $20 per day for 23 days in December, the rate will be averaged over 31 days at $14.84 per day for the qualifying patient. The rate differential is prospective for a full month. At the end of each month, the rate will remain the same or be renegotiated at the request of either the State or the provider. To obtain a new rate or the continuation of the existing rate differential, the provider must provide actual cost experience. The cost experience is limited to "direct cost". These direct costs are wages, benefits, and special supplies. Indirect costs are included in the existing basic flat rate. The amount paid will be subtracted from the nursing cost center when future rates are set to avoid duplicate payments.

FACILITY COST PROFILE forms will be included in the State Plan in 1997 per Roy Dunn. (See Rick Horsley for copies of the forms on disk.)

COMPUTATION OF PROPERTY COST REIMBURSEMENT

Every provider will receive at least two dollars per patient day as a reimbursement for property cost. Qualifying providers may receive, in addition to this base rate amount, a Property Cost Differential. This differential will be computed by using the following methodology:

1. A provider's Weighted Current Property Cost and Weighted Historical Property Cost will be added together to arrive at Total Property Cost.

2. Two dollars will be subtracted from the provider's Total Property Cost. This two dollars will become part of the provider's base rate. A provider's base rate will include two dollars for property even if the provider's Total Property Cost is less than two dollars.

3. If a provider's Total Property Cost is more than two dollars, the amount of Total Property Cost remaining after subtracting two dollars as described in step 2 above will become the provider's Property Cost Differential. Providers whose Total Property Cost is two dollars or less will not receive a Property Cost Differential as part of their reimbursement.

DEFINITIONS

Weighted Current Property Cost
: Weighted Current Property Cost is 85 percent of a provider's Current Property Cost Per Diem.

Current Property Cost Per Diem
: Current Property Cost Per Diem is computed by dividing a provider's Current Property Cost by 90 percent of the maximum possible patient days allowable in the cost report from which the provider's March 27, 1981, reimbursement rate was computed.

Current Property Cost
: Current Property Cost is the amount of allowable property cost determined by the Department of Health, Division of Health Care Financing and used in computing a provider's March 27, 1981, reimbursement rate.

Weighted Historical Property Cost
: Weighted Historical Property Cost is 15 percent of a provider's Historical Cost Per Diem.

Historical Cost Per Diem
: Historical Cost Per Diem is a provider's Historical Cost Reimbursement divided by 90 percent of the maximum possible patient days allowable in the cost report from which the provider's March 27, 1981, reimbursement rate was computed.

Historical Cost Reimbursement
: Historical Cost Reimbursement is a provider's pro-rata share of Aggregate Current Property Cost based on the provider's Historical Property Cost Percentage.

COMPUTATION OF PROPERTY COST REIMBURSEMENT (Continued)

Aggregate Current Property Cost

Aggregate Current Property Cost is the total of all providers' Current Property Cost.

Historical Property Cost Percentage

Historical Property Cost Percentage is the percentage that each provider's Historical Property Cost bears to the total of all providers' Historical Property Cost.

Historical Property Cost

Historical Property Cost is the provider's hypothetical total historical property cost computed by discounting Average Current Replacement Cost back to the year when a provider's beds were first licensed by the State. Historical Property Cost will be aggregated for each provider by accumulating the average annual depreciation and mortgage interest cost for each bed using the appropriate discounted replacement cost and mortgage rates for the year in which each bed was first licensed. Depreciation and interest cost will be computed assuming a 30-year useful life and with reference to construction cost inflators provided by the Utah State Building Board and average commercial mortgage rates for new homes, published by the U.S. Department of Commerce.

Average Current Replace Cost

Average Current Replacement Cost is the average replacement cost per bed for long-term care providers whose facilities have been appraised by the Utah State Tax Commission and whose appraisal was on file with the Department of Health, Division of Health Care Financing on April 1, 1981. The average cost per bed is computed by adding together all appraised building replacement costs. These costs will then be divided by the number of beds licensed by the State in the appraised facilities at the time each appraisal was completed.

APPLICATION OF INFLATION FACTOR

The inflation factor used to increase nursing home rates will be projected by a market basket index. The market basket methodology is contained in a special report by KMG Main Hurdman dated October 29, 1985. The project will continue to be made using the sum of least squares linear regression where the natural log is used, rather than the index itself. The most current 12-month history for each index will be used for the projection.

See **Roy Dunn** for the:

KMG Mail Hurdman, Study of the Utah Nursing Home Inflation Index, October 29, 1985

Appendix A - Utah's SNF Market Basket Index

Appendix B - Nursing Home Inflation Rate Index Survey

Appendix C - Total Costs for Nursing Homes by Line Item for Full Year - Cost Reports from 7-1-83 - 12-31-84

Appendix D - Percent Changes in Various Indexes

See **Roy Dunn** for:

Nursing Home Rates

Type of Service - Definition of a Claim